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Commentary

The Crucial Role of Criterion A: A Response to Maier's Commentary

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We thank Maier for his thoughtful comments (this issue, pp. 925–926) and appreciate the opportunity to further explicate our views regarding the Criterion A problem. According to Maier, the obvious conclusion to be drawn from our article (Weathers & Keane, 2007) is that Criterion A should be eliminated. We believe the opposite, given the current conceptual and empirical status of the posttraumatic stress disorder (PTSD) construct.

First, he states "an event is never *per se* traumatic, but only with respect to a particular individual" (this issue, p. 925–926). However, this does not mean that trauma is defined solely on the basis of subjective appraisal. As McNally (2004) noted, reality constrains appraisal, and "When appraisal closely tracks reality, it becomes redundant with objective features of the event. When appraisal overestimates threat, vulnerability factors are likely to account for more of the variance than properties of the event itself" (p. 5). Criterion A in *DSM-IV* takes subjective appraisal into account, but only in a bounded way: A1 establishes a threshold of stressor severity based on a relatively objective standard, and A2 requires consideration of subjective appraisal *only of those events meeting A1*.

Second, Maier calls for a phenomenological approach to PTSD, arguing that "*DSM* is not aiming to find out what a trauma is, but what a posttraumatic stress disorder is" (this issue, p. 925–926). However, although *DSM-III* has been largely descriptive and atheoretical with respect to etiology, it is not completely so. Several diagnostic categories other than PTSD require a presumptive etiological factor as a criterion, including acute stress disorder, adjustment disorder, reactive attachment disorder, and nearly all of what used to be called organic mental disorders. Also, inasmuch as PTSD has been a diagnostic category since *DSM-III* and has always included the stressor criterion, by definition this approach is part of what *DSM* is and does. Further, Spitzer, the primary architect of *DSM-III*, recently proposed not only retaining Criterion A, but tightening the definition for *DSM-V* (Spitzer, First, & Wakefield, 2007). Finally, unlike disorders such as schizophrenia or depression, PTSD cannot be defined solely on the basis of symptoms. As long as PTSD is conceptualized as a stress-response syndrome, the stressor will need to be incorporated somehow in the diagnostic criteria.

Third, Maier erroneously attributes to us the belief that "full-blown PTSD" can develop in response to low-magnitude stressors. To the contrary, we believe it is essential to distinguish between individuals who meet full diagnostic criteria and those who endorse symptoms based

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on non-Criterion A stressors. We tried to make this distinction explicit by using phrases such as "PTSD-like symptoms" and emphasizing the differential diagnosis of PTSD and adjustment disorder. The fact that some individuals with low-magnitude stressors endorse symptoms of PTSD does not mean they have the disorder. Such cases are likely due to insufficiently specific assessment methods. Even if not, we would conjecture that a syndrome of PTSD-like symptoms precipitated by a low-magnitude stressor is a different clinical entity than PTSD. Establishing equivalence between the two would require demonstrating empirically that the validity evidence for PTSD generalizes to the low-magnitude stressor syndrome.

Fourth, Maier argues that PTSD can be adequately diagnosed by Criteria B–F. Although the Kilpatrick et al. (1998) study suggests this approach might be feasible, we are somewhat pessimistic about achieving the necessary level of rigor in routine clinical assessment or even in many research settings. One problem is an overreliance on self-report measures. Such measures are useful, but tend to be highly face-valid and thus susceptible to symptom exaggeration and malingering. Further, they preclude clarification of ambiguous items or the use of clinical judgment in evaluating the clinical significance of symptom endorsements. Structured interviews are better, but their validity depends on the interviewer's skill, clinical judgment, and expertise, and they too are susceptible to malingering (cf. Rosen, 2004). Finally, the PTSD symptoms present a considerable challenge to valid assessment. Some, such as flashbacks, amnesia, and foreshortened future, are difficult to assess because they are inadequately conceptualized and poorly defined. Others, such as avoidance and numbing, are negative symptoms, which tend to be more difficult to assess than positive symptoms such as reexperiencing and hyperarousal.

Fifth, Maier cites Kilpatrick et al. (1998) as evidence that "there is no need for further 'safeguards' to prevent an excess of PTSD diagnoses" (this issue, p. 925–926). However, Criterion A does matter, as both Kilpatrick et al. and Breslau and Kessler (2001) have shown. Even with the rigorous assessment procedures used by Kilpatrick et al., there still were individuals who met the PTSD symptom criteria in response to a non-Criterion A event, which suggests that Criterion A increases diagnostic specificity. With less rigorous assessment, which is more typical in many clinical and research settings, even more individuals would be given a diagnosis of PTSD based on low-magnitude events. Such an outcome would represent an excessively broad application of the PTSD diagnosis.

Therefore, to us the most compelling argument for retaining Criterion A centers around bracket creep and its potential negative consequences (McNally, 2004), including increased heterogeneity of research participants, abuse of the diagnosis for financial reward or forensic outcome, and trivializing the suffering of survivors of catastrophic life events. From a scientific perspective the most important of these concerns is increased heterogeneity of research participants, because it could reduce discriminant validity and make it more difficult to identify core etiological processes. Despite the recent criticisms of PTSD, the construct is embedded in a well-articulated nomological net (Cronbach & Meehl, 1951), with extensive construct validity evidence from a wide variety of sources, including cross-sectional clinical presentation, course and outcome, structural studies, risk and resilience factors, response to treatment, animal models, genetics, neural imaging, neuroendocrinology, psychophysiology, and emotional and cognitive processing. Nonetheless, currently there is only limited evidence regarding the crucial domain of discriminant validity, i.e., evidence that continuous measures of PTSD are less strongly correlated with measures of other constructs than they are with other measures of PTSD, or that individuals with PTSD differ from those with other diagnoses on key biological or behavioral measures. Broadening the definition of PTSD would undermine efforts to establish discriminant validity and thereby establish PTSD as a distinct disorder.

Maier concludes that Criterion A "represents the profession of faith of psychotraumatology" (this issue, p. 925–926). Although that perspective may have merit, we intended something more prosaic in referring to the spirit of the definition of trauma, as in the *spirit* versus the *letter* of the law. We tried to discourage focusing too narrowly on specific aspects of the Criterion A language

and thereby missing the overall intent of its definition of trauma. Posttraumatic stress disorder should be considered an open scientific construct, and ultimately faith has little to do with how it is conceptualized and investigated. The cumulative scientific evidence will determine whether it is a valid disorder as currently defined or whether it needs to be modified or even replaced by a more valid construct.

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